Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

Soc. Sec. # _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School / College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Email: _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS# _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (eg. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐

10. Women Only:	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	**Angina**	☐	☐	**Hay Fever / Allergies**	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent if minor)

Doctor's Comments _____

_____ Signature _____ Date _____

Stephen L. Vickers, D.D.S.
Quality Cosmetic and Family Dentistry
13810 Champion Forest Drive, Ste 204
Houston, Texas 77069
281-440-1200

PERMISSION TO DISCLOSE TREATMENT WITH OTHERS

Today's Date:_____

I, _____, give permission to the staff of Vickers Family Dental to discuss my treatment plan, treatment options, financial arrangements, and any health concerns associated with my treatment, with the following person(s):

_____

Name Relationship

_____

Name Relationship

HIPAA requires that we obtain your consent to use and disclose your protected health information for the purposes of carrying out treatment, obtaining payments, and carrying on healthcare operations for your care. By signing this form, you agree to allow Vickers Family Dental to discuss your treatment plan, treatment options, financial arrangements, and any health concerns associated with your treatment, with the above person(s).

_____

Signature of Patient Date

_____

Witness Date

Stephen L. Vickers, DDS
13810 Champion Forest Dr., Suite 204
Houston, Texas 77069
Phone 281-440-1200 Fax 281-440-3578

Patient Acknowledgement

Welcome! We value our patients and their dental health is our primary concern. Each patient is treated on an individual basis. Today you will be asked to complete a medical history for Dr. Vickers to review. As a new patient, the assistant will take diagnostic radiographs and Dr. Vickers may request that models be taken. Dr. Vickers will do a thorough intra and extra oral examination and discuss your treatment options with you. A treatment plan will then be developed for you addressing your dental needs. Depending on the complexity of your treatment plan, you may be asked to return for another visit for Dr. Vickers to explain your choices for treatment and the estimated cost of the treatment. We appreciate you choosing our office for your dental needs. It is our goal to make you as comfortable as possible, therefore we have outlined our available financial payment options and general information for your convenience.

Appointments

Time is reserved with Dr. Vickers or the hygienist for each appointment. We require a 24 hour advance notice if you are unable to keep your scheduled appointment. Cancellations and missed appointments without 24 hour advance notice will be charged $75.00 per hour. Appointments for treatment require a 50% deposit.

Saturday Appointments

Saturday appointments require a credit card on file. Saturday appointments for treatment require payment in advance. We must have a 72 hour cancellation notice or you will be charged a $100 per hour cancellation fee to your credit card, no exceptions.

Insurance

Dental insurance is a highly complex subject and can create confusion for many patients. The dental benefits that you receive are based on the terms negotiated between your employer and the dental insurance company, not our dental office. We will verify that your insurance is current and in effect. If the insurance company will assign the benefit directly to Dr. Vickers, we will file and accept the insurance as a courtesy. The patients out of pocket expense may be handled with one of the methods mentioned below. All insurance quotes are an estimate....there is no guarantee the insurance company will pay the amount estimated. After the claim has been submitted we will do as much as we can to assure that the claim is paid within a 30 day period. However, if after 30 days, the insurance has not paid Dr. Vickers, it will be the patient's responsibility to pay the open balance in full. There is an 18% interest charge on all accounts over 60 days past due. Should you have dual insurance we will be happy to assist you in filing both insurances, however the above financial rules apply.

Forms of payment

We accept cash, Visa, Mastercard, Discover, Apple Pay, American Express, debit cards, and Care Credit.

I have read and I understand the Patient Acknowledgement and I agree to the above policies.

Patient Signature:_____ **Date:**_____

Stephen L. Vickers, DDS
13810 Champion Forest Dr., Suite 204
Houston, Texas 77069
Phone 281-440-1200 Fax 281-440-3578

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT CONSENT FORUSE AND DISCLOSURE OF HEALTH INFORMATION

HIPAA requires that we obtain your consent to use and disclose your protected health information for the purposes of carrying out treatment, obtaining payments, and carrying on healthcare operations for your care. By signing this consent form you will have acknowledged that you have read our Notice of Privacy Practices. You have the right to revoke this Consent by submitting your revocation to us in writing. Any action we took prior to your revocation will not be affected. We may choose to discontinue your treatment if you revoke your consent for us to use and disclose your health information for the reasons stated above.

I, _____, (print your name here) have read the Notice of Privacy Practices and consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature:_____ Date:_____

OR

Personal Representative's Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that any action you took prior to my revocation will not be affected. As a result of my revocation, you may elect to discontinue treating me.

Signature:_____Date:_____

This document is not a substitution for legal advice.

NOTICE OF PRIVACY PRACTICES

YOUR PATIENT RIGHTS

*You may request a copy of this notice and we will provide one to you.
*You may request in writing that we communicate your health information by alternative means such as email or fax or to alternative locations.
*You have a right to copies of your own health information. Your request must be submitted in writing to our HIPAA Compliance Officer either by mail or in person. We will let you know if any copying fees will be assessed. If there are copying fees, those fees will not exceed that which is allowable by the TSBDE rules and regulations.
*You may request that we implement additional restrictions on the use and disclosure of your private health information and we will determine whether or not the request is feasible.
*You may request that we amend your health information. This request must be in writing along with an explanation for the needed amendment. Keep in mind that we may deny your request but will maintain a copy of your request in your patient file.
*You are entitled to a list of occurrences in which we or our business associates have disclosed your private health information for reasons other than for treatment, payment, or healthcare operations for the past 6 years. Submit your request in writing.

USES AND DISCLOSURES FOR YOUR PRIVATE HEALTH INFORMATION

*To yourself
*To family and/or friends that you authorize for the purposes of helping with your healthcare or for payment of services.
*To obtain payment
*To other healthcare providers involved in your care
*To notify your family or representative about your care and health status as needed.
*To cooperate with law enforcement for reasons not limited to but including abuse, neglect, domestic violence, or crime victim.
*To military authorities if you are personnel of the Armed Forces and the information is needed for lawful intelligence, counterintelligence, or other national security purpose.
*To correctional institutions if you are an inmate.
*To facilitate our own quality assessments and improvements, reviewing competence of healthcare professionals, evaluation of practical performance, training programs, accreditation, certifications, licensing, or credentialing activities.
*To provide you with appointment reminders such as voicemail or mailers.

QUESTIONS AND COMPLAINTS

*If you suspect that we have violated your privacy rights or are concerned about the disclosure of your health information, you may complain by using the contact information provided on this notice or may contact the U.S. Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you if you file a complaint or voice your concerns.

*If you have questions you may direct them to the contact officer.

Contact Officer: Stephanie Vickers
Telephone: 281-440-1200 Fax: 281-440-3578
Email: vickersdental@aol.com
Address: 13810 Champion Forest Drive, Suite 204, Houston, Texas 77069